pharmacologic or local mucosal factors or others explained these variable efficacy estimates. More challenging issues to come even PrEP can demonstrate the effectiveness to minimize the risk of HIV infection, but numerous questions will remain about its implementation outside of the research context; such as intermittent use of the drugs, inducing drug resistance, drug safety for long-term use, costs of drug and appropriate monitoring program, risk compensation and combination with other effective HIV prevention methods.

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Type: Invited Presentation

Final Abstract Number: 06.004
Session: Getting to Zero: Antiretrovirals as a Tool for Prevention
Date: Thursday, June 14, 2012
Time: 10:15-12:15
Room: Lotus 5-7

Implementingpre-exposure prophylaxis (PrEP) – Are we ready?

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While global prevention strategies can guide PrEP implementation, determining whether and how PrEP should be implemented is a local decision that requires strong leadership and country-specific approaches best suited to combat local HIV epidemics. Optimal PrEP implementation ensures that it is integrated into existing services as part of a multifaceted strategy that includes condom use, sexually-transmitted infections treatment, other proven prevention approaches, behavior interventions to address adherence and risk behavior, regular HIV testing, safety screening and long-term monitoring. Clear policies are needed regarding for whom PrEP is recommended, whether cost of PrEP is subsidized and how PrEP is distributed. Rights to access PrEP and delivery of PrEP in acceptable and non-stigmatizing settings are important considerations.

Sufficient uptake of PrEP in populations at high risk for HIV is crucial to impact HIV transmission, and active outreach to the hidden population is needed. Motivation for potential users to adopt PrEP could be driven by their own perceive risks, the efficacy of PrEP and a perceived opportunity to safely engage in unprotected sex. Communication of PreP's partial efficacy is important and could alleviate misuse of PrEP as well as improve adherence to PrEP and regular HIV testing. Cost, potential side effects and regular HIV testing are some of the barriers to adopting PrEP. It is unlikely that PrEP implementation will be successful in low- and middle-income countries unless it is heavily government-subsidized.

The process for constructing an optimal package for PrEP implementation will vary between settings and will require input from stakeholders including policy makers, providers, potential users and advocacy groups. There is an urgent need for pilot PrEP implementation programs to inform the optimal strategy prior to its roll-out. Long-term monitoring of PrEP uptake, adherence, resistance and cost-effectiveness will be important.

This presentation will discuss recent findings on issues related to PrEP implementation and will offer a perspective on implementing PrEP in Asian settings.

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Role of media scanning and verification system as a supplemental tool to disease outbreak detection & reporting under integrated disease surveillance project (IDSP)-India

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Background: Media scanning can supplement conventional disease surveillance systems to more rapidly detect outbreaks so that timely and appropriate action can be taken. To address this need in India a Media Scanning & Verification Cell (MSVC) was established on July 2008 under the Integrated Disease Surveillance Project (IDSP) at the National Centre for Disease Control (NCDC), Delhi.

Methods: Print, electronic media and television reports are scanned manually for unusual health events daily by a team of assistants. Unusual health events are analyzed by trained epidemiologists who generate Media Alerts that are disseminated electronically to relevant State and District Health Officers and followed up by phone for verification. Verified Media Alert reports are distributed to responsible health authorities and stakeholders for appropriate public health action.

Results: A mean number of 4 Media Alert reports are generated each day. A total of 1685 alerts were reported in 42 months (July 2008 to December 2011). Of these 1241 (73.7%) were verified as real events and 183 (10.9%) were considered outbreaks by local health officials. Most events were from internet (57%) or print media (24%) sources. Unusual health events were identified from 26 of 28 Indian States and 3 of 7 Union Territories with majority reporting from Uttar Pradesh (21.1%), Delhi (8.6%), Karnataka (6.7%) and Andhra Pradesh, Gujarat, West Bengal, Rajasthan, Haryana and Orissa (5-6% each). The most common disease events identified were food-borne and diarrhea (29.1%), dengue (10.68%), influenza and respiratory disease (8.1%) and malaria (7.4%). The sensitivity of MSVC to detect outbreaks was 14.8% with more than half of outbreaks detected before they were identified by the conventional surveillance system.

Conclusion: In India, the MSVC serves as an Early Warning System gathering unconfirmed media reports of public health significance in real time and immediately disseminating the information to the public health community electronically for verification and action. It often identifies outbreaks before the conventional reporting system, helping initiate an earlier response and containment. It has proven to be a highly effective supplemental tool in the timely detection and management of public health threats in India.

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